UNFRIED
CHIROPRACTIC AND ACTIVE RELEASE TECHNIQUE CLINIC

Registration Form

Please print this page, complete the form, and bring to your appointment

PATIENT INFORMATION

Patient's Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If no, what is your legal name?	Former Name:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:		Social Security Number:		Home Phone Number: ( )	
P.O. Box:	City:	State:	Zip Code:		
Occupation:	Employer:		Employer Phone Number: ( )		
Chose clinic because.../ Referred to clinic by... (please check one box):		❑ Dr.	❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

Primary Insurance:	Group # | Policy #	ID #	Phone:
Secondary Insurance:	Group # | Policy #	ID #	Phone:

Occupation:	Employer:	Employer Address:	Employer Phone Number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's Name:	Subscriber's S.S.No.:	Birth Date: / /	Address:	Phone:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Sex: M / F

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignments.

B. I authorize payment of any medical benefit from third parties for benefits subitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payments to me or you based in whole, or in part, up on the charges made for your services.

C. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.

D. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Unfried Chiropractic are paid in full.

Patient/Guardian Signature

Date

Patient Financial Policy

Please print this page, complete the form, and bring to your appointment

Thank you for choosing our pratice as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It Is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, information, etc.)

Co-Pays

All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to price complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Workers' Compensation and Automobile Accidents

In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appoitment or pay for your visit at the time of service.

Missed Appoitments

We require a 24-hour notice of appointment cancellation. Appointments missed and are not previosuly canceled may be charged a fee of $25.

Returned Checks

The charge for a returned checks $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to a collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over to collection, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

I, _____ have read the above financial policy and understand my financial responsibility to healthcare provider.

Patient Signature **Date** **Witness Signature** **Date**

Consent to Release Information

Please print this page, complete the form, and bring to your appointment

I hereby consent to the use or disclosure, by Unfried Chiropractic, of my individually identifiable health information/ protected health information described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

☐ **I consent to the disclosure and the use of the Health Information described above to the following person(s) or organization(s) as noted below:**

Please list any family members, guardians, friends, or legal counsel with whom we are allowed to discuss your treatment or billing issues. Dependents over the age of 18 must give consent for release of information; they may indicate "unrestricted" and name one or both parents. The fact that they are over 18 does require us to "protect" their health information and does require consent for release of information. Information regarding dependents under 18 can only be released to either parent or legal guardian (unless there is a court order restriction) and requires parental consent for release other than as allowed by law.

Relationship _____

Relationship _____

Relationship _____

Relationship _____

☐ **I *DO NOT* want my information shared with anyone other than myself**

Comments

_____

_____

_____

_____

Print Name _____

Parent Signature _____

Parent/Guardian if under 18 _____

Relationship _____ **Date** _____

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Patient Health Questionnaire

Please print this page, complete the form, and bring to your appointment

Patient Name _____ **Date** _____

Describe your symptoms _____

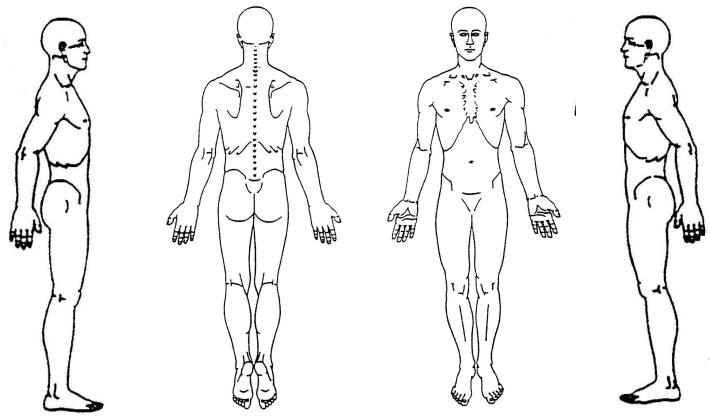
- **When did your symptoms start?** _____
- **How did your symptoms begin?** _____

How often do you experience your symptoms?
1. Constantly (76-11% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50% of the day)
4. Intermittently (0-25% of the day)

What describes the nature of your symptoms?
1. Sharp
2. Dull Ache
3. Numb
4. Shooting
5. Burning
6. Tingling

How are your symptoms changing?
1. Getting better
2. Not changing
3. Getting worse

Indicate where you have pain or other symptoms



During the last 4 weeks, indicate the average intensity of your symptoms: 1 being ***None*** and 10 being ***Unbearable***

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

During the last 4 weeks, how much has pain interfered with your normal work (outside and inside of the home)
1. Not at all. 2. A little bit. 3. Moderately. 4. Quite a bit. 5. Extremely.

During the last 4 weeks, how much of the time has your condition interfered with your social activities?
1. All of the time. 2. Most of the time. 3. Some of the time. 4. A little of the time. 5. None of the time.

In general, would you say your overall health right now is....
1. Excellent. 2. Very Good. 3. Good. 4. Fair. 5. Poor.

Who have you seen for your symptoms?
1. No one 2.Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

- **What treatment did you receive and when?** _____
- **What tests have you had for your symptoms and when were they performed?**

1. X-Ray (date: _____) 2. MRI (date:_____) 3. CT Scan (date:_____) 4. Other

Have you had similar symptoms in the past? Yes No

- If you have received treatment in the past for the same or similar symptoms, who did you see?

1. This Office 2.Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

What is your occupation? _____

- If you are not retired, a homemaker, or a student, what is your current work status?

1. Full-time 2.Part-time 3. Self-employed 4. Unemployed 5. Off work 6. Other

Patient Signature _____ **Date** _____

Informed Consent to Chiropractic Treatment

Please print this page, complete the form, and bring to your appointment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures including a comprehensive exam, diagnostic x-rays, and physical therapy techniques on myself, or on the patient named below for which I am legally responsible, by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include, but are not limited to, fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name of Patient

Patient Signature **Date**

Signature of Patient's Representative (if minor) **Date**

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Patient Vital Intake Questionnaire

Please print this page, complete the form, and bring to your appointment

Name _____ **Cell Phone** _____ **Work Phone** _____

Birthdate (MM/DD/YYYY) _____ **Age** _____ **Height** _____ **Weight** _____

Complaints and Treatment/Palliative Action (what makes it better):

_____

_____

List ALL surgeries/ trauma/ medications/ allergies (please provide dates, age, or year as best you can):

_____

_____

_____

Family Medical History (check all that apply):

- ❑ obesity
- ❑ diabetes
- ❑ stroke
- ❑ heart disease
- ❑ seizures
- ❑ high blood pressure
- ❑ cancer
- ❑ other: _____

Your Habits:

- ❑ cigarettes
- ❑ street drugs (explain below) _____
- ❑ coffee (____ cups per day)
- ❑ tea (____ cups per day)
- ❑ bitter chocolate
- ❑ alcohol (____ drinks per week)
- ❑ sweet or milk chocolate
- ❑ sugar
- ❑ artificial sweeteners
- ❑ salt
- ❑ marijuana (❑ occasionally ❑ often)
- ❑ cola or carbonated beverages (____ cups per day)

Cravings:

_____

Notes:

_____

_____

General:

- ❑ poor appetite
- ❑ insomnia
- ❑ cold hands
- ❑ fevers
- ❑ cravings
- ❑ sudden energy drops at (time)… _____
- ❑ strong thirst for…. _____
- ❑ heavy appetite
- ❑ fatigue
- ❑ cold feet
- ❑ chills
- ❑ localized weakness
- ❑ poor sleep
- ❑ tremors
- ❑ cold back
- ❑ night sweats
- ❑ poor coordination
- ❑ peculiar tastes and/or smells… _____
- ❑ bleed or bruise easily (where?) _____
- ❑ heavy sleep
- ❑ vertigo
- ❑ cold abdomen
- ❑ sweat easily
- ❑ change in appetite

(Please continue to pg. 2) ⟶

PVIQ Cont. - Pg. 2

Please print this page, complete the form, and bring to your appointment

Skin and Hair:

- ❑ rashes
- ❑ eczema
- ❑ change in hair/skin texture
- ❑ ulcerations
- ❑ acne
- ❑ purpura
- ❑ hives
- ❑ dandruff
- ❑ itching
- ❑ loss of hair
- ❑ other: _____

Head, Eyes, Ears, Nose, and Throat:

- ❑ dizziness
- ❑ eye strain
- ❑ color blindness
- ❑ ringing in ears
- ❑ mucus
- ❑ teeth problems
- ❑ gum problems
- ❑ sores on lips or tongue
- ❑ recurrent sore throats
- ❑ night blindness
- ❑ sinus problems
- ❑ concussions
- ❑ eye pain
- ❑ cataracts
- ❑ poor hearing
- ❑ dry throat
- ❑ jaw clicks
- ❑ spots in eyes
- ❑ grinding teeth
- ❑ facial pain
- ❑ glasses
- ❑ earaches
- ❑ headaches (location and frequency) _____
- ❑ migraines (location and frequency) _____
- ❑ poor vision
- ❑ blurry vision
- ❑ nose bleeds
- ❑ dry mouth
- ❑ copious saliva

Cardiovascular:

- ❑ high blood pressure
- ❑ dizziness
- ❑ irregular heartbeat
- ❑ low blood pressure
- ❑ fainting
- ❑ phlebitis
- ❑ chest pain
- ❑ blood clots
- ❑ swelling in the hands and/or feet
- ❑ cold hands and/or feet
- ❑ difficulty breathing
- ❑ other: _____

Respiratory:

- ❑ cough
- ❑ pneumonia
- ❑ production of phlegm
  color: _____
- ❑ coughing blood
- ❑ asthma
- ❑ bronchitis
- ❑ tight chest
- ❑ difficulty breathing when lying down

Gastrointestinal:

- ❑ nausea
- ❑ gas
- ❑ bad breath
- ❑ constipation
- ❑ pain or cramps
- ❑ vomiting
- ❑ belching
- ❑ rectal pain
- ❑ bloody stools
- ❑ diarrheas
- ❑ black stool
- ❑ hemorrhoids
- ❑ sensitive abdomen
- ❑ laxative use:
  _____ /per wk.
  type: _____
- ❑ bowel movement:
  frequency _____
  color _____
  odor _____
  texture/form _____

(Please continue to pg. 3) ⟶

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PVIQ Cont. - Pg. 3

Please print this page, complete the form, and bring to your appointment

Genito-Urinary:

- ❑ pain on urination
- ❑ frequent urination
- ❑ blood in urine
- ❑ urgency to urinate
- ❑ unable to hold urine
- ❑ kidney stones
- ❑ venereal disease
- ❑ impotency
- ❑ wake up to urinate — how often: _____ /night — time: _____
- ❑ other _____

Pregnancy and Gynecology:

- ❑ vaginal discharge
- ❑ clots
- ❑ vaginal sores
- ❑ breast lumps
- ❑ changes in body/psyche prior to menstruation
- ❑ premature births
- ❑ miscarriages
- ❑ irregular periods
- ❑ number of pregnancies _____
- ❑ age of first period _____
- ❑ last period (date & duration) _____
- ❑ menopause (date) _____
- ❑ last PAP (date) _____
- ❑ birth control (type) _____

Musculoskeletal:

- ❑ neck pain
- ❑ back pain _____
- ❑ joint pain _____
- ❑ muscle pain
- ❑ other _____

Neuropsychological:

- ❑ seizures
- ❑ anxiety
- ❑ concussion
- ❑ depression
- ❑ poor memory
- ❑ easily stressed
- ❑ areas of numbness
- ❑ bad temper
- ❑ considered/attempted suicide
- ❑ treated for emotional problems
- ❑ other _____